SENATE AMENDMENTS

2nd Printing

By: Bonnen of Galveston, Guillen H.B. No. 2327

A BILL TO BE ENTITLED

AN ACT

relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

ARTICLE 1. PREAUTHORIZATION

SECTION 1.01. Section 843.348(b), Insurance Code, is amended to read as follows:

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the fifth [~~10th~~] business day after the date a request is made, a list of health care services that [~~do not~~] require preauthorization and information concerning the preauthorization process.

SECTION 1.02. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.3481, 843.3482, 843.3483, and 843.3484 to read as follows:

Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance

organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the health maintenance organization requires from the physician or provider ordering or requesting the service to approve a request for that service;

(C) the applicable screening criteria using Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding preauthorization approval and denial rates for the service in the preceding year and for each previous year the preauthorization requirement was in effect, including statistics in the following categories:

(i) physician or provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned on external appeal; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider written notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the health maintenance organization's newsletter or network bulletin, if any.

(b) For a change in a preauthorization requirement or process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance

organization shall provide each participating physician or provider written notice of the change in the preauthorization requirement and disclose the change in the health maintenance organization's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization shall update its Internet website to disclose the change to the health maintenance organization's preauthorization requirements or process and the date and time the change is effective.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, waives the health maintenance organization's preauthorization requirements with respect to any health care service affected by the violation, and any health care service affected by the violation is considered preauthorized by the health maintenance organization.

Sec. 843.3484. EFFECT OF PREAUTHORIZATION WAIVER. A waiver of preauthorization requirements under Section 843.3483 may not be construed to:

(1) authorize a physician or provider to provide

health care services outside of the physician's or provider's applicable scope of practice as defined by state law; or

(2) require the health maintenance organization to pay for a health care service provided outside of the physician's or provider's applicable scope of practice as defined by state law.

SECTION 1.03. Section 1301.135(a), Insurance Code, is amended to read as follows:

(a) An insurer that uses a preauthorization process for medical care or [~~and~~] health care services shall provide to each preferred provider, not later than the fifth [~~10th~~] business day after the date a request is made, a list of medical care and health care services that require preauthorization and information concerning the preauthorization process.

SECTION 1.04. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Sections 1301.1351, 1301.1352, 1301.1353, and 1301.1354 to read as follows:

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about the preauthorization process readily accessible to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) conspicuously in a location on the Internet

website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve a request for the service;

(C) the applicable screening criteria using Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding year and for each previous year the preauthorization requirement was in effect, including statistics in the following categories:

(i) physician or health care provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on internal appeal;

(v) denials overturned on external appeal; and

(vi) total annual preauthorization requests, approvals, and denials for the service.

(c) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide to each preferred provider written notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the insurer's newsletter or network bulletin, if any.

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide each preferred provider written notice of the change in the preauthorization requirement and disclose the change in the

insurer's newsletter or network bulletin, if any, not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an insurer shall update its Internet website to disclose the change to the insurer's preauthorization requirements or process and the date and time the change is effective.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, waives the insurer's preauthorization requirements with respect to any medical care or health care service affected by the violation, and any medical care or health care service affected by the violation is considered preauthorized by the insurer.

(b) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1354. EFFECT OF PREAUTHORIZATION WAIVER. (a) A waiver of preauthorization requirements under Section 1301.1353 may not be construed to:

(1) authorize a physician or health care provider to provide medical care or health care services outside of the

physician's or health care provider's applicable scope of practice as defined by state law; or

(2) require the insurer to pay for a medical care or health care service provided outside of the physician's or health care provider's applicable scope of practice as defined by state law.

(b) The provisions of this section may not be waived, voided, or nullified by contract.

ARTICLE 2. UTILIZATION, INDEPENDENT, AND PEER REVIEW

SECTION 2.01. Section 4201.002(12), Insurance Code, is amended to read as follows:

(12) "Provider of record" means the physician or other health care provider with primary responsibility for the health care[~~, treatment, and~~] services provided to or requested on behalf of an enrollee or the physician or other health care provider that has provided or has been requested to provide the health care services to the enrollee. The term includes a health care facility where the health care services are [~~if treatment is~~] provided on an inpatient or outpatient basis.

SECTION 2.02. Sections 4201.151 and 4201.152, Insurance Code, are amended to read as follows:

Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician licensed to practice medicine in this state and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician licensed to practice medicine

in this state.

Sec. 4201.152. UTILIZATION REVIEW UNDER [~~DIRECTION OF~~] PHYSICIAN. A utilization review agent shall conduct utilization review under the supervision and direction of a physician licensed to practice medicine in this [~~by a~~] state [~~licensing agency in the United States~~].

SECTION 2.03. Subchapter D, Chapter 4201, Insurance Code, is amended by adding Section 4201.1525 to read as follows:

Sec. 4201.1525. UTILIZATION REVIEW BY PHYSICIAN. (a) A utilization review agent that uses a physician to conduct utilization review may only use a physician licensed to practice medicine in this state.

(b) A payor that conducts utilization review on the payor's own behalf is subject to Subsection (a) as if the payor were a utilization review agent.

SECTION 2.04. Section 4201.153(d), Insurance Code, is amended to read as follows:

(d) Screening criteria must be used to determine only whether to approve the requested treatment. Before issuing an adverse determination, a utilization review agent must obtain a determination of medical necessity by referring a proposed [~~A~~] denial of requested treatment [~~must be referred~~] to:

(1) an appropriate physician, dentist, or other health care provider; or

(2) if the treatment is requested, ordered, provided, or to be provided by a physician, a physician licensed to practice medicine in this state who is of the same or a similar specialty as

that physician [~~to determine medical necessity~~].

SECTION 2.05. Sections 4201.155, 4201.206, and 4201.251, Insurance Code, are amended to read as follows:

Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW PROCEDURES. (a) A utilization review agent may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

(b) This section may not be construed to release a health insurance policy or health benefit plan from full compliance with this chapter or other applicable law.

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity, the [~~or~~] appropriateness, or the experimental or investigational nature[~~,~~] of a health care service, the agent shall provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss with a physician licensed to practice medicine in this state the patient's treatment plan and the clinical basis for the agent's determination.

(b) If the health care service described by Subsection (a) was ordered, requested, or provided, or is to be provided by a physician, the opportunity described by that subsection must be with a physician licensed to practice medicine in this state who is of the same or a similar specialty as that physician.

Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A utilization review agent may delegate utilization review to qualified personnel in the hospital or other health care facility in which the health care services to be reviewed were or are to be provided. The delegation does not release the agent from the full responsibility for compliance with this chapter or other applicable law, including the conduct of those to whom utilization review has been delegated.

SECTION 2.06. Sections 4201.252(a) and (b), Insurance Code, are amended to read as follows:

(a) Personnel employed by or under contract with a utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law, including licensing requirements.

(b) Personnel, other than a physician licensed to practice medicine in this state, who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols must be a nurse, physician assistant, or other health care provider qualified and licensed or otherwise authorized by law and the appropriate licensing agency in this state to provide the requested service.

SECTION 2.07. Section 4201.356, Insurance Code, is amended to read as follows:

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) The procedures for appealing an adverse determination

must provide that a physician licensed to practice medicine in this state makes the decision on the appeal, except as provided by Subsection (b) or (c).

(b) For a health care service ordered, requested, provided, or to be provided by a physician, the procedures for appealing an adverse determination must provide that a physician licensed to practice medicine in this state who is of the same or a similar specialty as that physician makes the decision on appeal, except as provided by Subsection (c).

(c) If not later than the 10th working day after the date an appeal is denied the enrollee's health care provider states in writing good cause for having a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review and who is licensed or otherwise authorized by the appropriate licensing agency in this state to manage the medical or dental condition, procedure, or treatment shall review the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received.

SECTION 2.08. Sections 4201.357(a), (a-1), and (a-2), Insurance Code, are amended to read as follows:

(a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care or a denial of

continued hospitalization. That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; [~~and~~]

(2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and

(3) for a review of a health care service:

(A) ordered, requested, provided, or to be provided by a health care provider who is not a physician, is licensed or otherwise authorized by the appropriate licensing agency in this state to provide the service in this state; or

(B) ordered, requested, provided, or to be provided by a physician, is licensed to practice medicine in this state.

(a-1) The procedures for appealing an adverse determination must include, in addition to the written appeal and the appeal described by Subsection (a), a procedure for an expedited appeal of a denial of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy. That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; [~~and~~]

(2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and

(3) for a review of a health care service:

(A) ordered, requested, provided, or to be

provided by a health care provider who is not a physician, is licensed or otherwise authorized by the appropriate licensing agency in this state to provide the service in this state; or

(B) ordered, requested, provided, or to be provided by a physician, is licensed to practice medicine in this state.

(a-2) An adverse determination under Section 1369.0546 is entitled to an expedited appeal. The physician or, if appropriate, other health care provider deciding the appeal must consider atypical diagnoses and the needs of atypical patient populations. The physician must be licensed to practice medicine in this state and the health care provider must be licensed or otherwise authorized by the appropriate licensing agency in this state.

SECTION 2.09. Section 4201.359, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) A physician described by Subsection (b)(2) must comply with this chapter and other applicable laws and be licensed to practice medicine in this state. A health care provider described by Subsection (b)(2) must comply with this chapter and other applicable laws and be licensed or otherwise authorized by the appropriate licensing agency in this state.

SECTION 2.10. Sections 4201.453 and 4201.454, Insurance Code, are amended to read as follows:

Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be:

(1) reviewed by a health care provider of the

appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state; and

(2) conducted in accordance with standards developed with input from a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state.

Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. A specialty utilization review agent shall conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service in this [~~by a~~] state [~~licensing agency in the United States~~].

SECTION 2.11. Sections 4201.455(a) and (b), Insurance Code, are amended to read as follows:

(a) Personnel who are employed by or under contract with a specialty utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law of this state, including licensing laws.

(b) Personnel who obtain oral or written information directly from a physician or other health care provider must be a nurse, physician assistant, or other health care provider of the same specialty as the agent and who are licensed or otherwise authorized to provide the specialty health care service in this [~~by a~~] state [~~licensing agency in the United States~~].

SECTION 2.12. Sections 4201.456 and 4201.457, Insurance

Code, are amended to read as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity, the [~~or~~] appropriateness, or the experimental or investigational nature[~~,~~] of a health care service, the agent shall provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is:

(1) of the same specialty as the agent; and

(2) licensed or otherwise authorized to provide the specialty health care service in this state.

Sec. 4201.457. APPEAL DECISIONS. A specialty utilization review agent shall comply with the requirement that a physician or other health care provider who makes the decision in an appeal of an adverse determination must be:

(1) of the same or a similar specialty as the health care provider who would typically manage the specialty condition, procedure, or treatment under review in the appeal; and

(2) licensed or otherwise authorized to provide the health care service in this state.

SECTION 2.13. Section 4202.002, Insurance Code, is amended by adding Subsection (b-1) to read as follows:

(b-1) The standards adopted under Subsection (b)(3) must:

(1) ensure that personnel conducting independent

review for a health care service are licensed or otherwise authorized to provide the same or a similar health care service in this state; and

(2) be consistent with the licensing laws of this state.

SECTION 2.14. Section 408.0043, Labor Code, is amended by adding Subsection (c) to read as follows:

(c) Notwithstanding Subsection (b), if a health care service is requested, ordered, provided, or to be provided by a physician, a person described by Subsection (a)(1), (2), or (3) who reviews the service with respect to a specific workers' compensation case must be of the same or a similar specialty as that physician.

SECTION 2.15. Subchapter B, Chapter 151, Occupations Code, is amended by adding Section 151.057 to read as follows:

Sec. 151.057. APPLICATION TO UTILIZATION REVIEW. (a) In this section:

(1) "Adverse determination" means a determination that health care services provided or proposed to be provided to an individual in this state by a physician or at the request or order of a physician are not medically necessary or are experimental or investigational.

(2) "Payor" has the meaning assigned by Section 4201.002, Insurance Code.

(3) "Utilization review" has the meaning assigned by Section 4201.002, Insurance Code, and the term includes a review of:

(A) a step therapy protocol exception request under Section 1369.0546, Insurance Code; and

(B) prescription drug benefits under Section 1369.056, Insurance Code.

(4) "Utilization review agent" means:

(A) an entity that conducts utilization review under Chapter 4201, Insurance Code;

(B) a payor that conducts utilization review on the payor's own behalf or on behalf of another person or entity;

(C) an independent review organization certified under Chapter 4202, Insurance Code; or

(D) a workers' compensation health care network certified under Chapter 1305, Insurance Code.

(b) A person who does the following is considered to be engaged in the practice of medicine in this state and is subject to appropriate regulation by the board:

(1) makes on behalf of a utilization review agent or directs a utilization review agent to make an adverse determination, including:

(A) an adverse determination made on reconsideration of a previous adverse determination;

(B) an adverse determination in an independent review under Subchapter I, Chapter 4201, Insurance Code;

(C) a refusal to provide benefits for a prescription drug under Section 1369.056, Insurance Code; or

(D) a denial of a step therapy protocol exception request under Section 1369.0546, Insurance Code;

(2) serves as a medical director of an independent review organization certified under Chapter 4202, Insurance Code;

(3) reviews or approves a utilization review plan under Section 4201.151, Insurance Code;

(4) supervises and directs utilization review under Section 4201.152, Insurance Code; or

(5) discusses a patient's treatment plan and the clinical basis for an adverse determination before the adverse determination is issued, as provided by Section 4201.206, Insurance Code.

(c) For purposes of Subsection (b), a denial of health care services based on the failure to request prospective or concurrent review is not considered an adverse determination.

SECTION 2.16. Section 1305.351(d), Insurance Code, is amended to read as follows:

(d) A [~~Notwithstanding Section 4201.152, a~~] utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter, including utilization review, or peer reviews under Section 408.0231(g), Labor Code, may only use doctors licensed to practice in this state.

SECTION 2.17. Section 1305.355(d), Insurance Code, is amended to read as follows:

(d) The department shall assign the review request to an independent review organization. An [~~Notwithstanding Section 4202.002, an~~] independent review organization that uses doctors to perform reviews of health care services under this chapter may only

use doctors licensed to practice in this state.

SECTION 2.18. Section 408.023(h), Labor Code, is amended to read as follows:

(h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~] utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this subtitle, including utilization review, may only use doctors licensed to practice in this state.

SECTION 2.19. Section 413.031(e-2), Labor Code, is amended to read as follows:

(e-2) An [~~Notwithstanding Section 4202.002, Insurance Code, an~~] independent review organization that uses doctors to perform reviews of health care services provided under this title may only use doctors licensed to practice in this state.

ARTICLE 3. TRANSITIONS; EFFECTIVE DATE

SECTION 3.01. The changes in law made by Article 1 of this Act apply only to a request for preauthorization of medical care or health care services made on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed on or after that date. A request for preauthorization of medical care or health care services made before January 1, 2020, or on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed before that date is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3.02. The changes in law made by Article 2 of this Act apply only to utilization, independent, or peer review

requested on or after the effective date of this Act. Utilization, independent, or peer review requested before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3.03. This Act takes effect September 1, 2019.

ADOPTED

MAY 22 2019

Secretary of the Senate

By: Buckingham H.B. No. 2327

Substitute the following for H.B. No. 2327:

By: Cain Lee Nichols C.S.H.B. No. 2327

A BILL TO BE ENTITLED

AN ACT

relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

ARTICLE 1. PREAUTHORIZATION

SECTION 1.01. Section 843.348(b), Insurance Code, is amended to read as follows:

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the fifth [~~10th~~] business day after the date a request is made, a list of health care services that [~~do not~~] require preauthorization and information concerning the preauthorization process.

SECTION 1.02. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.3481, 843.3482, and 843.3483 to read as follows:

Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance

organization's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) except as provided by Subsection (c) or (d), conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) except for the screening criteria under Paragraph (4)(C), be written in plain language that is easily understandable by enrollees, physicians, providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of the health care services for which the health maintenance organization requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the health maintenance organization requires from the physician or provider ordering or requesting the service to approve a request for that service;

(C) the applicable screening criteria, which may include Current Procedural Terminology codes and International

Classification of Diseases codes; and

(D) statistics regarding preauthorization approval and denial rates for the service in the preceding year, including statistics in the following categories:

(i) physician or provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on appeal; and

(v) total annual preauthorization requests, approvals, and denials for the service.

(c) This section may not be construed to require a health maintenance organization to provide specific information that would violate any applicable copyright law or licensing agreement. A health maintenance organization is required to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement, a summary of the withheld information sufficient to allow a licensed physician or provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the health maintenance organization's medical necessity or appropriateness determinations.

(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the health maintenance organization has received from a third party with which the health maintenance organization has contracted, the health maintenance organization may, instead of making that

information publicly available on the health maintenance organization's Internet website, provide the material to a physician or provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization that uses a preauthorization process for health care services shall provide notice of the new or amended preauthorization requirement in the health maintenance organization's newsletter or network bulletin, if any, and on the health maintenance organization's Internet website.

(b) For a change in a preauthorization requirement or process that removes a service from the list of health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or providers, a health maintenance organization shall provide notice of the change in the preauthorization requirement in the health maintenance organization's newsletter or network bulletin, if any, and on the health maintenance organization's Internet website not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, a health maintenance organization shall update its Internet website to

disclose the change to the health maintenance organization's preauthorization requirements or process and the date and time the change is effective.

Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to any other penalty or remedy provided by law, a health maintenance organization that uses a preauthorization process for health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any health care service affected by the violation.

SECTION 1.03. Section 1301.135(a), Insurance Code, is amended to read as follows:

(a) An insurer that uses a preauthorization process for medical care or [~~and~~] health care services shall provide to each preferred provider, not later than the fifth [~~10th~~] business day after the date a request is made, a list of medical care and health care services that require preauthorization and information concerning the preauthorization process.

SECTION 1.04. Subchapter C-1, Chapter 1301, Insurance Code, is amended by adding Sections 1301.1351, 1301.1352, and 1301.1353 to read as follows:

Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS. (a) An insurer that uses a preauthorization process for medical care or health care services shall make the requirements and information about the preauthorization process readily accessible

to insureds, physicians, health care providers, and the general public by posting the requirements and information on the insurer's Internet website.

(b) The preauthorization requirements and information described by Subsection (a) must:

(1) be posted:

(A) except as provided by Subsection (c) or (d), conspicuously in a location on the Internet website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) except for the screening criteria under Paragraph (4)(C), be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve

a request for the service;

(C) the applicable screening criteria, which may include Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding year, including statistics in the following categories:

(i) physician or health care provider type and specialty, if any;

(ii) indication offered;

(iii) reasons for request denial;

(iv) denials overturned on appeal; and

(v) total annual preauthorization requests, approvals, and denials for the service.

(c) This section may not be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. An insurer is required to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement, a summary of the withheld information sufficient to allow a licensed physician or other health care provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the insurer's medical necessity or appropriateness determinations.

(d) If a requirement or information described by Subsection (a) is licensed, proprietary, or copyrighted material that the

insurer has received from a third party with which the insurer has contracted, the insurer may, instead of making that information publicly available on the insurer's Internet website, provide the material to a physician or health care provider who submits a preauthorization request using a nonpublic secured Internet website link or other protected, nonpublic electronic means.

(e) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS. (a) Except as provided by Subsection (b), not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an insurer that uses a preauthorization process for medical care or health care services shall provide notice of the new or amended preauthorization requirement in the insurer's newsletter or network bulletin, if any, and on the insurer's Internet website.

(b) For a change in a preauthorization requirement or process that removes a service from the list of medical care or health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to insureds, physicians, or health care providers, an insurer shall provide notice of the change in the preauthorization requirement in the insurer's newsletter or network bulletin, if any, and on the insurer's Internet website not later than the fifth day before the date the change takes effect.

(c) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an insurer

shall update its Internet website to disclose the change to the insurer's preauthorization requirements or process and the date and time the change is effective.

(d) The provisions of this section may not be waived, voided, or nullified by contract.

Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition to any other penalty or remedy provided by law, an insurer that uses a preauthorization process for medical care or health care services that violates this subchapter with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any medical care or health care service affected by the violation.

(b) The provisions of this section may not be waived, voided, or nullified by contract.

ARTICLE 2. UTILIZATION, INDEPENDENT, AND PEER REVIEW

SECTION 2.01. Section 4201.002(12), Insurance Code, is amended to read as follows:

(12) "Provider of record" means the physician or other health care provider with primary responsibility for the health care[~~, treatment, and~~] services provided to or requested on behalf of an enrollee or the physician or other health care provider that has provided or has been requested to provide the health care services to the enrollee. The term includes a health care facility where the health care services are [~~if treatment is~~] provided on an inpatient or outpatient basis.

SECTION 2.02. Sections 4201.151 and 4201.152, Insurance Code, are amended to read as follows:

Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician licensed to practice medicine in this state and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician licensed to practice medicine in this state.

Sec. 4201.152. UTILIZATION REVIEW UNDER [~~DIRECTION OF~~] PHYSICIAN. A utilization review agent shall conduct utilization review under the direction of a physician licensed to practice medicine in this [~~by a~~] state [~~licensing agency in the United States~~].

SECTION 2.03. Section 4201.153(d), Insurance Code, is amended to read as follows:

(d) Screening criteria must be used to determine only whether to approve the requested treatment. Before issuing an adverse determination, a utilization review agent must obtain a determination of medical necessity and appropriateness by referring a proposed [~~A~~] denial of requested treatment [~~must be referred~~] to:

(1) an appropriate physician, dentist, or other health care provider; or

(2) if the treatment is requested, ordered, provided, or to be provided by a physician, a physician licensed to practice medicine who is of the same or a similar specialty as that physician

[~~to determine medical necessity~~].

SECTION 2.04. Sections 4201.155, 4201.206, and 4201.251, Insurance Code, are amended to read as follows:

Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW PROCEDURES. (a) A utilization review agent may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

(b) This section may not be construed to release a health insurance policy or health benefit plan from full compliance with this chapter or other applicable law.

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity, the [~~or~~] appropriateness, or the experimental or investigational nature[~~,~~] of a health care service, the agent shall provide the health care provider who ordered, requested, provided, or is to provide the service a reasonable opportunity to discuss with a physician licensed to practice medicine the patient's treatment plan and the clinical basis for the agent's determination.

(b) If the health care service described by Subsection (a) was ordered, requested, or provided, or is to be provided by a physician, the opportunity described by that subsection must be with a physician licensed to practice medicine who is of the same or a similar specialty as that physician.

Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A utilization review agent may delegate utilization review to qualified personnel in the hospital or other health care facility in which the health care services to be reviewed were or are to be provided. The delegation does not release the agent from the full responsibility for compliance with this chapter or other applicable law, including the conduct of those to whom utilization review has been delegated.

SECTION 2.05. Sections 4201.252(a) and (b), Insurance Code, are amended to read as follows:

(a) Personnel employed by or under contract with a utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law, including applicable licensing requirements.

(b) Personnel, other than a physician licensed to practice medicine, who obtain oral or written information directly from a patient's physician or other health care provider regarding the patient's specific medical condition, diagnosis, or treatment options or protocols must be a nurse, physician assistant, or other health care provider qualified and licensed or otherwise authorized by law and an appropriate licensing agency in the United States to provide the requested service.

SECTION 2.06. Section 4201.356, Insurance Code, is amended to read as follows:

Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY REVIEW. (a) The procedures for appealing an adverse determination

must provide that a physician licensed to practice medicine makes the decision on the appeal, except as provided by Subsection (b).

(b) If not later than the 10th working day after the date an appeal is requested or denied the enrollee's health care provider requests [~~states in writing good cause for having~~] a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review and who is licensed or otherwise authorized by the appropriate licensing agency in the United States to manage the medical or dental condition, procedure, or treatment shall review the denial or the decision denying the appeal. The specialty review must be completed within 15 working days of the date the health care provider's request for specialty review is received.

SECTION 2.07. Sections 4201.357(a), (a-1), and (a-2), Insurance Code, are amended to read as follows:

(a) The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, [~~or~~] a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; [~~and~~]

(2) is of the same or a similar specialty as the health

care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and

(3) for a review of a health care service:

(A) ordered, requested, or to be provided by a health care provider who is not a physician, is licensed or otherwise authorized by an appropriate licensing agency in the United States; or

(B) ordered, requested, or to be provided by a physician, is licensed to practice medicine in the United States.

(a-1) The procedures for appealing an adverse determination must include, in addition to the written appeal and the appeal described by Subsection (a), a procedure for an expedited appeal of a denial of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance policy. That procedure must include a review by a health care provider who:

(1) has not previously reviewed the case; [~~and~~]

(2) is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal; and

(3) for a review of a health care service:

(A) ordered, requested, or to be provided by a health care provider who is not a physician, is licensed or otherwise authorized by the appropriate licensing agency in this state to provide the service in this state; or

(B) ordered, requested, or to be provided by a physician, is licensed to practice medicine in this state.

(a-2) An adverse determination under Section 1369.0546 is entitled to an expedited appeal. The physician or, if appropriate, other health care provider deciding the appeal must consider atypical diagnoses and the needs of atypical patient populations. The physician must be licensed to practice medicine in the United States and the health care provider must be licensed or otherwise authorized by an appropriate licensing agency in the United States.

SECTION 2.08. Section 4201.359, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) A physician described by Subsection (b)(2) must comply with this chapter and other applicable laws and be licensed to practice medicine. A health care provider described by Subsection (b)(2) must comply with this chapter and other applicable laws and be licensed or otherwise authorized by an appropriate licensing agency in the United States.

SECTION 2.09. Sections 4201.453 and 4201.454, Insurance Code, are amended to read as follows:

Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty utilization review agent's utilization review plan, including reconsideration and appeal requirements, must be:

(1) reviewed by a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state; and

(2) conducted in accordance with standards developed with input from a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in this state.

Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF PROVIDER OF SAME SPECIALTY. A specialty utilization review agent shall conduct utilization review under the direction of a health care provider who is of the same specialty as the agent and who is licensed or otherwise authorized to provide the specialty health care service in this [~~by a~~] state [~~licensing agency in the United States~~].

SECTION 2.10. Sections 4201.455(a) and (b), Insurance Code, are amended to read as follows:

(a) Personnel who are employed by or under contract with a specialty utilization review agent to perform utilization review must be appropriately trained and qualified and meet the requirements of this chapter and other applicable law of this state, including applicable licensing laws.

(b) Personnel who obtain oral or written information directly from a physician or other health care provider must be a nurse, physician assistant, or other health care provider of the same specialty as the agent and who are licensed or otherwise authorized to provide the specialty health care service by a [~~state~~] licensing agency in the United States.

SECTION 2.11. Sections 4201.456 and 4201.457, Insurance Code, are amended to read as follows:

Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity, the [~~or~~] appropriateness, or the experimental or

investigational nature[,] of a health care service, the agent shall provide the health care provider who ordered, requested, or is to provide the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agent's determination with a health care provider who is:

(1) of the same specialty as the agent; and

(2) licensed or otherwise authorized to provide the specialty health care service by a licensing agency in the United States.

Sec. 4201.457. APPEAL DECISIONS. A specialty utilization review agent shall comply with the requirement that a physician or other health care provider who makes the decision in an appeal of an adverse determination must be:

(1) of the same or a similar specialty as the health care provider who would typically manage the specialty condition, procedure, or treatment under review in the appeal; and

(2) licensed or otherwise authorized to provide the health care service by a licensing agency in the United States.

SECTION 2.12. Section 408.0043, Labor Code, is amended by adding Subsection (c) to read as follows:

(c) Notwithstanding Subsection (b), if a health care service is requested, ordered, provided, or to be provided by a physician, a person described by Subsection (a)(1), (2), or (3) who reviews the service with respect to a specific workers' compensation case must be of the same or a similar specialty as that physician.

SECTION 2.13. Section 1305.351(d), Insurance Code, is

amended to read as follows:

(d) A [~~Notwithstanding Section 4201.152, a~~] utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter, including utilization review, or peer reviews under Section 408.0231(g), Labor Code, may only use doctors licensed to practice in this state.

SECTION 2.14. Section 1305.355(d), Insurance Code, is amended to read as follows:

(d) The department shall assign the review request to an independent review organization. An [~~Notwithstanding Section 4202.002, an~~] independent review organization that uses doctors to perform reviews of health care services under this chapter may only use doctors licensed to practice in this state.

SECTION 2.15. Section 408.023(h), Labor Code, is amended to read as follows:

(h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~] utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this subtitle, including utilization review, may only use doctors licensed to practice in this state.

SECTION 2.16. Section 413.031(e-2), Labor Code, is amended to read as follows:

(e-2) An [~~Notwithstanding Section 4202.002, Insurance Code, an~~] independent review organization that uses doctors to perform reviews of health care services provided under this title may only use doctors licensed to practice in this state.

ARTICLE 3. JOINT INTERIM STUDY

SECTION 3.01. CREATION OF JOINT INTERIM COMMITTEE. (a) A joint interim committee is created to study, review, and report on the use of prior authorization and utilization review processes by private health benefit plan issuers in this state, as provided by Section 3.02 of this article, and propose reforms under that section related to the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in this state.

(b) The joint interim committee shall be composed of four senators appointed by the lieutenant governor and four members of the house of representatives appointed by the speaker of the house of representatives.

(c) The lieutenant governor and speaker of the house of representatives shall each designate a co-chair from among the joint interim committee members.

(d) The joint interim committee shall convene at the joint call of the co-chairs.

(e) The joint interim committee has all other powers and duties provided to a special or select committee by the rules of the senate and house of representatives, by Subchapter B, Chapter 301, Government Code, and by policies of the senate and house committees on administration.

SECTION 3.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. (a) The joint interim committee created by Section 3.01 of this article shall study data and other

information available from the Texas Department of Insurance, the office of public insurance counsel, or other sources the committee determines relevant to examine and analyze the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in this state.

(b) The joint interim committee shall propose reforms based on the study required under Subsection (a) of this section to improve the transparency of and patient outcomes under prior authorization and utilization review processes in this state.

(c) The joint interim committee shall prepare a report of the findings and proposed reforms.

SECTION 3.03. COMMITTEE FINDINGS AND PROPOSED REFORMS. (a) Not later than December 1, 2020, the joint interim committee created under Section 3.01 of this article shall submit to the lieutenant governor, the speaker of the house of representatives, and the governor the report prepared under Section 3.02 of this article. The joint interim committee shall include in its report recommendations of specific statutory and regulatory changes that appear necessary from the committee's study under Section 3.02 of this article.

(b) Not later than the 60th day after the effective date of this Act, the lieutenant governor and speaker of the house of representatives shall appoint the members of the joint interim committee in accordance with Section 3.01 of this article.

SECTION 3.04. ABOLITION OF COMMITTEE. The joint interim committee created under Section 3.01 of this article is abolished

and this article expires December 15, 2020.

ARTICLE 4. TRANSITIONS; EFFECTIVE DATE

SECTION 4.01. The changes in law made by Article 1 of this Act apply only to a request for preauthorization of medical care or health care services made on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed on or after that date. A request for preauthorization of medical care or health care services made before January 1, 2020, or on or after January 1, 2020, under a health benefit plan delivered, issued for delivery, or renewed before that date is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 4.02. The changes in law made by Article 2 of this Act apply only to utilization, independent, or peer review requested on or after the effective date of this Act. Utilization, independent, or peer review requested before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 4.03. This Act takes effect September 1, 2019.

ADOPTED

MAY 22 2019

Secretary of the Senate

FLOOR AMENDMENT NO. 1 BY D. Buckingham

Amend C.S.H.B. No. 2327 (senate committee printing) as follows:

(1) In SECTION 1.02 of the bill, in added Section 843.3481(b)(4)(D), Insurance Code (page 2, line 14), between "preceding" and "year", insert "calendar".

(2) In SECTION 1.02 of the bill, in added Section 843.3481(c), Insurance Code (page 2, lines 26-28), strike "is required to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement," and substitute "may, instead of making that information publicly available on the health maintenance organization's Internet website, supply".

(3) In SECTION 1.04 of the bill, in added Section 1301.1351(b)(4)(D), Insurance Code (page 3, line 57), between "preceding" and "year", insert "calendar".

(4) In SECTION 1.04 of the bill, in added Section 1301.1351(c), Insurance Code (page 3, line 68, through page 4, line 1), strike "is required to supply, in lieu of any information withheld on the basis of copyright law or a licensing agreement," and substitute "may, instead of making that information publicly available on the insurer's Internet website, supply".

(5) In SECTION 2.03 of the bill, strike amended Section 4201.153(d), Insurance Code (page 5, lines 10-21), and substitute the following:

(d) Screening criteria must be used to determine only whether to approve the requested treatment. Before issuing an adverse determination, a utilization review agent must obtain a determination of medical necessity and appropriateness by referring a proposed [~~A~~] denial of requested treatment [~~must be referred~~] to an appropriate physician, dentist, or other health

care provider [~~to determine medical necessity~~].

(6) In SECTION 2.04 of the bill, in added Section 4201.206(b), Insurance Code (page 5, lines 46-47), strike "who is of the same or a similar specialty as that physician".

(7) In SECTION 2.07 of the bill, in added Section 4201.357(a-1)(3)(A), Insurance Code (page 6, lines 56-57), strike "in this state to provide the service in this state" and substitute "in the United States".

(8) In SECTION 2.07 of the bill, in added Section 4201.357(a-1)(3)(B), Insurance Code (page 6, line 59), strike "in this state" and substitute "in the United States".

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 23, 2019

TO: Honorable Dennis Bonnen, Speaker of the House, House of Representatives

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB2327** by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.), **As Passed 2nd House**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code and Labor Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

Based on information provided by the Texas Department of Insurance, Employees Retirement System, State Office of Risk Management, Texas Department of Transportation, The University of Texas System Administration, and Texas A&M University System Administration, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill applies only to utilization, independent, or peer review that was requested on or after the effective date of the bill. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 479 State Office of Risk Management, 529 Health and Human Services Commission

LBB Staff: WP, CLo, CP

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 20, 2019

TO: Honorable Kelly Hancock, Chair, Senate Committee on Business & Commerce

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB2327** by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.), **Committee Report 2nd House, Substituted**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code and Labor Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

Based on information provided by the Texas Department of Insurance, Employees Retirement System, State Office of Risk Management, Texas Department of Transportation, The University of Texas System Administration, and Texas A&M University System Administration, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill applies only to utilization, independent, or peer review that was requested on or after the effective date of the bill. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 479 State Office of Risk Management, 529 Health and Human Services Commission

LBB Staff: WP, CLo, CP

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 3, 2019

TO: Honorable Kelly Hancock, Chair, Senate Committee on Business & Commerce

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB2327** by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.), **As Engrossed**

The fiscal implications of the bill cannot be determined at this time due to the inability to determine potential increased workers' compensation plan costs to the State Office of Risk Management (SORM) and state agencies.

This bill would amend the Insurance Code, Labor Code, and Occupations Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

SORM anticipates increased administrative costs and increased costs to state agencies relating to workers' compensation under the provisions of the bill. The fiscal implications of the bill cannot be determined at this time due to the inability to determine potential increased costs to SORM and state agencies. The bill would potentially increase the cost for contracted preauthorization review, reduce the number of contractors and physicians available for reviews, and increase the number of services preauthorized on first request, resulting in potential increased costs paid for medical services. Potential costs may be offset by fewer initial denials, resulting in decreased administrative costs.

Based on information provided by the Texas Department of Insurance, Employees Retirement System, Texas Medical Board, Texas Department of Transportation, The University of Texas System Administration, and Texas A&M University System Administration, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill applies only to utilization, independent, or peer review requested on or after the effective date of the bill. The bill would take effect on September 1, 2019.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 479 State Office of Risk Management, 503 Texas Medical Board, 529 Health and Human Services Commission, 601 Department of Transportation, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: WP, CLo, SGr, CP, AF, LR, CMa, DFR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

April 9, 2019

TO: Honorable Eddie Lucio III, Chair, House Committee on Insurance

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB2327** by Bonnen, Greg (relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers. Based on information provided by the Texas Department of Insurance and Employees Retirement System, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Health and Human Services Commission, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: WP, LR, CMa, SGr, CP, DFR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

March 25, 2019

TO: Honorable Eddie Lucio III, Chair, House Committee on Insurance

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: **HB2327** by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers.), **As Introduced**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers. Based on information provided by the Texas Department of Insurance and Employees Retirement System, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after September 1, 2019. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Health and Human Services Commission, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: WP, CMa, SGr, CP, LR, DFR